Date _____

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
Spaulding Building
95 Pleasant Street
CONCORD, NEW HAMPSHIRE

EMPLOYEE'S STATEMENT OF EMPLOYMENT STATUS

TO: _____ Phone#_____
Employee's Name SSN#_____

ADDRESS:_____
_____
_____
_____

Employer's Name _____ Injury Date _____

Requested by:_____
(Carrier Name/and to be returned to carrier)

The workers' compensation law, RSA 281-A:53-a, requires you as a person receiving disability benefits to file a report with the insurer no more than once every three (3) months. This report must list any changes in employment status (work for any employer or self-employment either full-time or part-time). This report must also list any changes in earnings received during the period indicated below.

This report covers the time: From_____to_____.

"EARNINGS" includes any cash, wages, or salary received from self-employment or from any employer. Earnings also include commissions, bonuses, and the cash value for all payments received in any medium other than cash (e.g. a building custodian receiving an apartment rent-free). Earnings do not include the benefits you receive under workers' compensation.

To comply with this requirement, please completely fill out the following information, date, sign, and return the form in the self-addressed postage prepaid envelope within 30 days of the date of this request. **This form must be signed and returned to the carrier or self-insurer named above even if you have no earnings. If you fail to return the form your payment may be suspended until you comply. The failure to file such a report or to file fully and accurately may also subject you to civil or criminal penalties.**

Please check the Yes/No responses:

I. Are you currently performing any work for which you receive earnings? Yes___No___.

If YES, please provide name and address of employer, the task you perform and earnings for this job**.**
_____
_____
_____
_____

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II. During the past three (3) months, did you perform any work for any period of time, no matter how briefly? Yes___No___.

If YES, please provide the name and address of employer, task performed, the dates of work and earnings received.

_____
_____
_____
_____

III. During the past three (3) months, were you self-employed for any period of time, no matter how briefly? Yes___No___.

If YES, please provide the name, address and nature of your self-employment business or businesses. Please include the gross profit, gross income and net income of each self-employment business during this time period.

_____
_____
_____
_____
_____

Any person who knowingly and with intent to defraud any insurance company or employer, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance or theft act, which is a crime.

I HEREBY CERTIFY THAT ALL THE STATEMENTS MADE IN RESPONSE TO QUESTIONS ON THIS FORM ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

Date Employee Signature

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***In addition to the benefits you are receiving, other benefits to which you may be entitled are*:**

- Medical treatment related to your work injury.
- Reimbursement for mileage to your physician and physical therapy.
- Prescriptions related to your work injury.
- Permanent impairment if such results from your injury (the amount is governed by law).
- Vocational rehabilitation services under certain circumstances.
- A cost of living adjustment if you are unable to work for three years or more and have been denied Social Security disability benefits.

***Also, your employer may have to provide you with*:**

- The opportunity for Temporary Alternative Duty.
- Reinstatement to employment if within 18 months of the date of injury your doctor releases you to full-time work without restrictions.

Please note that certain criteria and conditions apply to eligibility for many of these benefits. If you are represented by an attorney, you may wish to consult the attorney, otherwise, you may request information from the insurer; view the information on the Department of Labor's workers' compensation website (www.nh.gov/labor) or call the Workers' Compensation Division at (603) 271-3176.